State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Dear Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. Please complete the enclosed Medi-Cal provider enrollment application package and return it to:

California Department of Health Services
Provider Enrollment Branch
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413

PLEASE NOTE: Effective January 1, 2004, new law governing enrollment of providers in the Medi-Cal program resulted in a process for the Department of Health Services (Department) to more thoroughly review applicants applying to participate in the Medi-Cal program and established a new provisional provider status. In addition, it resulted in revisions to the provider enrollment application forms.

Please read all the instructions included in the application package carefully and complete each item requested. Incomplete application packages will be returned. Due to the volume of applications received, program staff are unable to reply to a request for the status of an application in process. Therefore, please allow for the 180 days stipulated in regulations for processing your application (or 90 days if you apply for preferred provisional provider status) prior to contacting the Department regarding the status of your application. Information about the completion of enrollment forms is located on the Medi-Cal Web site at **www.medi-cal.ca.gov**.

It is your responsibility to report to the Department any modifications to information previously submitted within 35 days of the change. Most changes may be reported on a *Medi-Cal Supplemental Changes* (DHS 6209, revised 7/04) form. However, if you are reporting a change of ownership of 50 percent or more, or a change of business address, you must complete a new application package.

Enrollment forms are available at **www.medi-cal.ca.gov** or by contacting the Telephone Service Center (TSC) at 1-800-541-5555. For more information about the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our Web site at **www.medi-cal.ca.gov** and click the "Provider Enrollment" link. If you have any questions, please submit your inquiry in writing to the above address

Provider Enrollment Branch
Payment Systems Division

Enclosures (Revised 10/04)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL PHYSICIAN APPLICATION/AGREEMENT

DO NOT USE correction tape, white out, or highlighter pen or ink of a similar type on this form.

This form is an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers must also provide additional information and documentation. Applicants may be subject to an on-site inspection prior to enrollment. Applicants or providers may be subject to unannounced visits prior to enrollment or approval for continued enrollment in the program. In addition to the application and requested documentation, a Medi-Cal Disclosure Statement (DHS 6207) must also be completed for enrollment or continued enrollment. Additional information can be found at the following Medi-Cal web site, Provider Enrollment link: www.medi-cal.ca.gov.

Omission of any information or documentation on this form or the failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations (CCR), Section 51000.50.

To request consideration for Preferred Provider Status, check the box and include all required documentation pursuant to the Provider Bulletin dated February 2004 or go to the Medi-Cal web site, Provider Enrollment link to Preferred Provider Status. Only those complete applications submitted with all qualifying documentation included will be processed with a preferred provider status.

Enrollment action requested (check all that apply); enter the date you are completing the application.

"New provider"—the applicant is not currently enrolled in the Medi-Cal program and would like to have a Medi-Cal provider number issued.

For any of the following actions checked, please provide a current Medi-Cal provider number:

"Change of business address"—the applicant is currently enrolled in the Medi-Cal program and is requesting to relocate to a new business address and vacate the old location.

"Additional business address"—the applicant is currently enrolled in the Medi-Cal program and is requesting a new Medi-Cal provider number be issued for an additional business location.

"Change of ownership"—there is a change of ownership as defined in Title 22, CCR, Section 51000.6.

"Sale of assets (50 percent or more)"—fifty (50) percent or more of the assets owned by the corporation, at the location for which a provider number has been issued, are sold or transferred.

"New Taxpayer ID number"—a new Taxpayer Identification Number (TIN) is issued by the IRS.

"Cumulative change of 50 percent or more in ownership or control"—there is a cumulative change of 50 percent or more in the person(s) with an ownership or control interest, as defined in Title 22, CCR, Section 51000.15, since the information provided in the last complete application package that was approved for enrollment.

"Add rendering provider"—add a rendering provider to a provider group applicant or an existing provider group. If this is a request to be added as a rendering provider to a provider group applicant, enter the provider group name. If this is a request to be added as a rendering provider to an existing provider group, enter that provider group provider number.

"Reactivate provider number"—you want to re-establish yourself as a Medi-Cal provider.

"Continued enrollment"—the applicant is currently enrolled as a Medi-Cal provider and has been requested by the Department to apply for continued enrollment in the Medi-Cal program. Do not check this box unless you have received notification from the Department, pursuant to Title 22, CCR, Section 51000.55. List current Medi-Cal provider number(s).

Check the box labeled "I intend to use my current..." if you intend to use your current provider number to bill for services delivered at this location while this application request is pending. This action places the provider on provisional provider status, pursuant to Title 22, CCR, Section 51000.51(b).

"Type of entity"—Check one box only which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, please attach a legible copy of the partnership agreement.

1. "Legal name"—the name listed with the Internal Revenue Service (IRS).
2. "Business name"—the name of the applicant or provider if different from that listed in number 1. If this is a fictitious business name, enter the Fictitious Name Permit number and effective date. Attach a legible copy of the Fictitious Name Permit to the application.
3. "Business telephone number"—the primary business telephone number used at the business address. A beeper number, cell phone, answering service, pager, facsimile machine, biller or billing service, or answering machine shall not be used as the primary business telephone.
4. "Provider group business address"—the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable. Check box a. if this address is a licensed hospital/health facility. Check box b. if all services are provided at this address. Check box c. if you are requesting an exception pursuant to Welfare and Institutions (W&I) Code, Section 14043.15(b)(2). Attach a list of all qualifying addresses.

5. "Pay-to address"—the address at which the applicant or provider wishes to receive payment. The pay-to address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
6. "Mailing address"—the address at which the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.
7. Enter the medical license number(s) of the applicant or provider. Attach a legible copy of the license. List the specialty(ies) and indicate if board certified or eligible.
8. Enter the Medicare billing number.
9. Enter the Taxpayer Identification Number (TIN) issued by the IRS under the name of the applicant or provider. Attach a legible copy of the IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification).
10. If the business is a sole proprietorship not using a TIN, enter the social security number of the sole proprietor. (See Privacy Statement on page 5.)
11. Enter the Clinical Laboratory Improvement Amendment (CLIA) certificate number. Attach a legible copy of the CLIA certificate. The name and address on the certificate must match the name and address as entered in numbers 1 and 4.
12. Enter the State Laboratory License/Registration number. Attach a legible copy of the license/registration.
13. Enter the driver's license or state-issued identification number and state of issuance of the individual named in number 1. Attach a legible copy to the application.
14. Enter the date of birth of the individual named in number 1.
15. Check (✓) the gender of the individual named in number 1.
16. Enter any local business license or permit numbers for any city or county or city and county where you conduct your business activities and attach copies to the application. If this does not apply to you, enter "N/A."
17. Enter the Seller's Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller's Permit. If this does not apply to you, enter "N/A."
18. Enter the requested information. Attach to this application a legible copy(ies) of applicant's current Certificate of Insurance for Liability Insurance that covers premises and operation for this address. If all services are provided exclusively in a licensed hospital or licensed health facility (as defined in Health and Safety Code, Section 1250), please provide a cover letter with the facility information as proof of liability insurance coverage.
19. Enter the requested information. Attach a legible copy(s) of applicant's current Certificate of Insurance for Professional Liability Insurance (malpractice insurance) to this application.
20. Enter the following information:
    - Whether the applicant or provider has hospital privileges.
      If not, please explain why (if arrangements have been made with another physician for admitting patients, please provide his/her name, address, and telephone number).
    - The name(s), address(es), and telephone number(s) of the hospital(s) where current privileges have been granted.

    Attach additional sheet if needed.

    Pursuant to Welfare and Institutions (W&I) Code, Section 14043.15(b)(2), when disclosed in the application package that the provider's practice includes the rendering of services, goods, supplies, or merchandise solely at one or more than one health facility as defined in Section 1250 of the Health and Safety Code; or clinic, as defined in Section 1204 of the Health and Safety Code; or medical therapy unit, for purposes of Section 123950 of the Health and Safety Code; or residence of the provider's patient; or office of a physician and surgeon involved in the care and treatment of the provider's patients, shall not be required to enroll at each such health facility, clinic, medical therapy unit, patient's residence or physician and surgeon's office location and may utilize the provider number granted upon enrollment for all such locations specified. Attach a list of all qualifying addresses.
21. If you are providing services in a hospital or clinic (facility), please complete this certification.
22. Print name of the physician signing the application. An original signature of the individual is required. Include the city, state, and the date where and when the application was signed.

✓ Remember to attach a legible copy of the following, if applicable:

- ❒ Driver's license or state-issued identification card
- ❒ TIN verification
- ❒ CLIA Certificate
- ❒ Medical license(s)
- ❒ Fictitious Name Permit
- ❒ State Laboratory License/Registration
- ❒ Signed Medi-Cal Disclosure Statement (DHS 6207)
- ❒ Certificate(s) of Insurance for Liability and Professional Liability Insurance
- ❒ Local business license(s) or permit(s)
- ❒ Seller's Permit

MEDI-CAL PHYSICIAN APPLICATION/AGREEMENT

FOR STATE USE ONLY

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: California Department of Health Services
  Provider Enrollment Branch
  MS 4704
  P.O. Box 997413
  Sacramento, CA 95899-7413
  (916) 323-1945

❒ Preferred provider status requested pursuant to Welfare and Institutions Code, Section 14043.26(c). All qualifying documentation and cover letter attached.

Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Enrollment action requested (check all that apply):

Date

❒ New provider

For any of the following actions, include current Medi-Cal provider number: _____

❒ Change of business address
❒ Additional business address
❒ Change of ownership
❒ Sale of assets (50 percent or more)
❒ New Taxpayer ID number
❒ Cumulative change of 50 percent or more in ownership or control
❒ Add rendering provider to:
  ❒ Provider group applicant—group name: _____
  ❒ Existing provider group—specify group provider number(s):_____
  _____

❒ Reactivate provider number

❒ Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, CCR, Section 51000.55.)

❒ I intend to use my current Medi-Cal provider number to bill for services delivered at this location while this application request is pending. I understand that I will be on provisional provider status during this time, pursuant to Title 22, CCR, Section 51000.51(b).

Type of entity (check one):

❒ Sole proprietor (unincorporated) ❒ Partnership ❒ Government ❒ Nonprofit—Type of nonprofit:_____
❒ Professional Medical Corporation—corporate number: _____ ❒ Other: _____

1. Legal name of applicant or provider (as listed with the IRS) (last) (first) (middle)

2. Business name, if different

3. Business telephone number ( )

Is this a fictitious business name? ❒ Yes ❒ No

If yes, list the Fictitious Business Name Permit number

Effective date

(Attach a legible copy of the Fictitious Business Name Permit issued by the Medical Board.)

4. Business address (number, street) | City | County | State | Nine-digit ZIP code

a. ❒ This address is a licensed hospital/health facility b. ❒ All services are provided at this location.
c. ❒ I am requesting an exception pursuant to W&I Code, Section 14043.15(b)(2). Attach a list of all qualifying addresses.

5. Pay-to address (number, street, P.O. Box number) | City | State | Nine-digit ZIP code

6. Mailing address (number, street, P.O. Box number) | City | State | Nine-digit ZIP code

7. Medical license number (attach a legible copy)

List specialty(ies)

YES NO
Board certified ❒ ❒
Board eligible ❒ ❒

8. Medicare billing number

9. Taxpayer Identification Number (TIN) (Attach a legible copy of the IRS form.)
__ __ — __ __ __ __ __ __ __

10. Social security number—if Sole Proprietor not using a TIN, you must disclose this number (See Privacy Statement on page 5.)
__ __ __ — __ __ — __ __ __ __

11. Clinical Laboratory Improvement Amendment (CLIA) certificate number (attach a legible copy)

12. State Laboratory License/Registration number (attach a legible copy)

13. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

14. Date of birth

15. Gender
❒ Male ❒ Female

16. Any local business license numbers/permits (attach legible copies)

17. Seller's Permit number (attach a legible copy or proof of exemption)

18. **Proof of Liability Insurance**—Applicant must attach a copy of their certificate of insurance for this address.

Name of insurance company

Insurance policy number	Date policy issued (mm/dd/yyyy)	Expiration date of policy (mm/dd/yyyy)

Insurance agent's name—(first) (middle) (last) (Jr., Sr., etc.)

Telephone number	Fax number	E-mail address
( )	( )	

❒ Facility-based provider. Attach cover letter.

19. **Proof of Professional Liability Insurance**—Applicant must attach a copy of their certificate of (malpractice) insurance to this application.

Name of insurance company

Insurance policy number	Date policy issued (mm/dd/yyyy)	Expiration date of policy (mm/dd/yyyy)

Insurance agent's name—(first) (middle) (last) (Jr., Sr., etc.)

Telephone number	Fax number	E-mail address
( )	( )	

20. **Hospital Privileges**

Do you have current hospital privileges? ❒ Yes ❒ No

If no, please explain: _____

If yes, please enter the following (attach additional sheet if needed):

Name of hospital		Telephone number	
		( )	
Address (number, street)	**City**	**State**	**ZIP code**

❒ Pursuant to W&I Code, Section 14043.15(b)(2), my practice is solely at the location(s) listed here, for which one provider number is requested. A list of all qualifying address must be attached to the application.

If you are applying as a rendering provider to a group, please disregard this question.

21. **Self certification and statement of intent to employ a separate billing method for hospital/clinic-based physician.** ***(To be completed only if the practice location is a licensed facility.)***

The undersigned hospital/clinic and physician agree to the following requirement for the issuance of a Medi-Cal provider number to the hospital/clinic-based physician. It is agreed and understood by _____ and
(Physician Name)
_____ that there shall be no duplicate
(Hospital/Clinic Name)
billing for inpatient services rendered to Medi-Cal beneficiaries. All billing for inpatient services provided by the physician to Medi-Cal beneficiaries shall be billed using the physician's provider number. To ensure the money paid to the physician is not included in the cost settlement process, we recommend that the hospital/clinic set up a separate nonreimbursable cost center to account for all clinic-related payments. Additionally, the hospital/clinic should keep track of overhead support costs related to the reimbursable costs. At year end the costs related to the guarantee to the physician's clinical billings should be easily identifiable by our audit staff on your cost report. If it appears impossible/impractical for you to set up a separate cost center, then the direct cost related to physician clinical activities at a minimum should be eliminated from the trial balance cost via an A-8 adjustment on your cost report. This method of billing will become effective for services performed on or after _____. We declare under penalty of perjury
(Date)
under the laws of the State of California that the foregoing information is true and correct to the best of our knowledge.

Hospital/clinic name

Address (number, street)	City	State	ZIP code

Print name of authorized hospital/clinic representative	Authorized hospital/clinic representative signature	Date

Print physician name	Business name

Physician signature	Date

22. **I declare under penalty of perjury under the laws of the State of California that the foregoing information and all attachments are true, accurate, and complete to the best of my knowledge and belief. I understand that incorrect or inaccurate information may affect my eligibility to receive Medi-Cal reimbursement and that I must report changes in the above information within 35 days to the Department of Health Services, Provider Enrollment Branch. I hereby further declare that I will abide by all Medi-Cal laws and regulations and the Medi-Cal program policies and procedures as published in the Medi-Cal Provider Manual. I understand that it is my responsibility to read the manual and its updates.**

Printed name of physician (last) (first) (middle)

Signature of the physician

Executed at: _____, _____ on _____
(City) (State) (Date)

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the California Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code, Section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, (916) 323-1945.